APPENDIX 18
INSTRUCTIONS FOR COMPLETION OF THE WMAP DRUG CLAIM FORM

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "optional" or "not required" is indicated.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. This card should always be presented prior to rendering the service. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured (subscriber) information.

The WMAP only reimburses providers for disposable medical supply items listed in the Wisconsin Medicaid Disposable Medical Supply (DMS) Maximum Allowable Fee Schedule.

ELEMENT 1 - PROVIDER NAME AND ADDRESS
Enter the name (exactly as indicated on the provider's notification of certification letter), address, city, state, and zip code of the billing provider.

ELEMENT 2 - VARIANCE CHECK (not required)

ELEMENT 3 - PROVIDER NUMBER
Enter the billing provider's eight-digit Medical Assistance provider number.

ELEMENT 4 - INSURED'S ID NUMBER
Enter the recipient's 10-digit Medical Assistance identification number exactly as it appears on the current Medical Assistance identification card.

ELEMENT 5 - LAST NAME
Enter the recipient's last name exactly as it appears on the current Medical Assistance identification card.

ELEMENT 6 - FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's current Medical Assistance identification card.

ELEMENT 7 - SEX
Enter "M" for male and "F" for female.

ELEMENT 8 - PATIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., January 5, 1978 would be 01/05/78) as it appears on the Medical Assistance identification card.

ELEMENT 9 - NURSING HOME FACILITY PROVIDER NUMBER (not required)

ELEMENT 10 - PRESCRIBER NUMBER (DEA NUMBER)
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained, use one of the following default codes:

XX5555555 - Prescriber's DEA number cannot be obtained
XX9999991 - Prescriber does not have a DEA number

ELEMENT 11 - DATE PRESCRIBED
Enter the date shown on the prescription in MM/DD/YY format.

ELEMENT 12 - DATE FILLED
Enter the date that the prescription was filled/refilled in MM/DD/YY format.

ELEMENT 13 - REFILL
Enter the refill indicator. The first element of the refill indicator is the refill being billed. This must be zero if the date prescribed equals the date filled. The second element is the total refills allowed (e.g., the second refill of a six refill prescription would be "2/6".) A non-refillable prescription would be "0/0".

ELEMENT 14 - NDC
Enter the 11-digit National Drug Code (NDC) or WMAP assigned code for the item being billed. (Refer to the Medicaid DMS Maximum Allowable Fee Schedule for the current NDC.)

ELEMENT 15 - DAYS SUPPLY
Enter the estimated day's supply that has been prescribed for the recipient. This must be a whole number greater than zero (e.g., if a prescription is expected to last for five days, enter "5").

ELEMENT 16 - QUANTITY
Enter the quantity in the specified unit of measure according to the Medicaid DMS Maximum Allowable Fee Schedule.

ELEMENT 17 - CHARGE
Enter the total charge for each line item. The charge should represent your usual and customary fees, including the dispensing fee.

ELEMENT 18 - UNIT DOSE (not required)

ELEMENT 19 - PRESCRIPTION NUMBER
Enter the prescription number. Each DMS item billed must have a unique prescription number.

ELEMENT 20 - MAC WAIVER (not required)

ELEMENT 21 - NAME/STRENGTH/PACKAGE SIZE/MANUFACTURER (not required)

ELEMENT 22 - PLACE OF SERVICE
Enter the appropriate single-digit place of service code for each drug or supply billed.

Code	Description
0	Pharmacy
4	Home (DMS Services only)

ELEMENT 23 - PROVIDER SIGNATURE AND DATE
The provider or the authorized representative must sign in element 23. The month, day, and year the form is signed must also be entered in MM/DD/YY format (e.g., February 3, 1992 would be 02/03/92).

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 24 - PATIENT ACCOUNT NUMBER (OPTIONAL)
Provider may enter the patient's internal office account number. This number will appear on the EDS Remittance and Status Report (maximum of 12 alphanumeric characters).

ELEMENT 25 - PRIOR AUTHORIZATION
The seven-digit prior authorization number from the approved prior authorization form must be entered in element 25. Do not attach a copy of the prior authorization to the claim. Services authorized under multiple prior authorizations must be billed on separate claims.

ELEMENT 26 - OTHER INSURANCE
Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third party billing according to Section IX of Part A of the WMAP Provider Handbook.

- When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, the service does not require third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" on the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, one of the following codes MUST be indicated. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the private insurer.
OI-Y	YES, the card indicates other coverage but it was not billed for reasons including, but not limited to: - Recipient denies coverage or will not cooperate; - The provider knows the service in question is noncovered by the carrier; - Insurance failed to respond to initial and follow-up claim; or - Benefits not assignable or cannot get an assignment.

- When "Other Coverage" on the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use "H" if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

ELEMENT 27 - T18
When a recipient's Medical Assistance identification card indicates Medicare coverage, Medicare must be billed prior to the WMAP. If Medicare does not pay, one of the following Medicare disclaimer codes MUST be indicated (the description is not required):

Code	Description
1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
5	Provider not Medicare certified for the benefits provided.
6	Recipient not eligible for Medicare.
7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
8	Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medical Assistance identification card indicates no Medicare coverage, this element may be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefit (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding submission of claims for dual entitlees.

ELEMENT 28 - TOTAL CHARGE
Enter the total charges for this claim.

ELEMENT 29 - OI AMOUNT
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00.

NOTE: This element is not used for the Medicare paid amount.

When applicable, enter the recipient spenddown amount and the word "spenddown" in the empty box between elements 29 and 30.

ELEMENT 30 - NET BILLED
Enter the balance due by subtracting any other insurance amount and recipient spenddown from the amount in element 28.

APPENDIX 19
SAMPLE DRUG CLAIM FORM

ICN (DO NOT WRITE IN THIS SPACE)

E.D.S. FEDERAL CORP.
6406 BRIDGE ROAD
MADISON, WI 53784

TYPEWRITER — ALIGNMENT

1 PROVIDER NAME ADDRESS	2 VARIANCE	WISCONSIN MEDICAL ASSISTANCE PROGRAM
I.M. Billing 100 W. Williams Anytown, WI 55555	3 PROVIDER NUMBER 87654321	DRUG CLAIM FORM

RECIPIENT INFORMATION

4 MEDICAL ASSISTANCE NUMBER	5 LAST NAME	6 FIRST NAME	7 SEX	8 DATE OF BIRTH	9 NURSING HOME FACILITY NUMBER
1234567890	Recipient	Ima	F	MM/DD/YY	

BILLING INFORMATION

	10 PRESCRIBER NUMBER	11 DATE PRESC	12 DATE FILLED	13 REFILL	14 NDC			15 DAYS SUPPLY	16 QUANTITY	17 CHARGE
1	AB1234567	07/09/92	07/09/92	0	10	12345	1234 12	14	14	$ XX.XX
	18 UC	19 PRESCRIPTION NUMBER	20 MAC	21 DRUG DESCRIPTION - REQUIRED IF COMPOUND - OTHERWISE OPTIONAL					22 POS	
		123		dressing change kit					0	
2	AB1234567	07/09/92	07/23/92	1	10	12345	1234 12	14	14	$ XX.XX
		123		dressing change kit					0	
3	AB1234567	07/09/92	08/09/92	2	10	12345	1234 12	14	14	$ XX.XX
		123		dressing change kit					0	
4										$
5										$
6										$

23 CERTIFICATION

I CERTIFY THE SERVICES AND ITEMS FOR WHICH REIMBURSEMENT IS CLAIMED ON THIS CLAIM FORM WERE PROVIDED TO THE ABOVE NAMED RECIPIENT PURSUANT TO THE PRESCRIPTION OF A LICENSED PHYSICIAN, PODIATRIST OR DENTIST. CHARGES ON THIS CLAIM FORM DO NOT EXCEED MY USUAL AND CUSTOMARY CHARGE FOR THE SAME SERVICES OR ITEMS WHEN PROVIDED TO PERSONS NOT ENTITLED TO RECEIVE BENEFITS UNDER WISCONSIN'S MEDICAL ASSISTANCE PROGRAM.
I UNDERSTAND THAT ANY PAYMENT MADE IN SATISFACTION OF THIS CLAIM WILL BE DERIVED FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT MAY BE SUBJECT TO PROSECUTION UNDER APPLICABLE FEDERAL OR STATE LAW.

PHARMACIST'S OR DISPENSING PHYSICIAN'S SIGNATURE: I. M. Provider DATE: MM/DD/YY

24 PATIENT ACCOUNT NUMBER: JED1234

25 PRIOR AUTHORIZATION NUMBER	26 TYPE	27 PLACE	28 TOTAL CHARGES
1234567	P	7	$ XXX.XX

POS	DESCRIPTION
0	PHARMACY
3	DOCTOR'S OFFICE
4	HOME (IV-IM SERVICES ONLY)
7	N/H EXTENDED CARE FACILITY
8	SKILLED NURSING FACILITY

29 OTHER AMOUNT: $ XX.XX
spenddown XX.XX
30 BALANCE: $ XX.XX

483 CDD FORM AUTHORIZED UNDER HSS 106.03(1) - REV. 5-87

APPENDIX 19a
DRUG CLAIM FORM
ELECTRONIC SCREEN

PHARMACY ECS SCREEN
The field numbers on the ECS screen correspond with the numbered data elements on the pharmacy claim form

WELCOME TO ELECTRONIC CLAIMS SUBMISSION
EDS - WISCONSIN MEDICAID

BP NBR 3 MID 4 L NAME 5 F NAME 6
FP NBR 9 OI 26 MSC 27 PCN 24 PA NBR 25

PRESCRIBR 10	RX DT 11	FILL DT 12	RF 13	NDC 14	DAYS 15	QTY 16	CHARGE 17	UD 18	RX NBR 19	MAC 20	POS 22

TOT BILL 28 OI PAID 29 PAT PAID 29A NET BILL 30

Doc #1 Page #1 Field #4 Form: PHARMACY 01-31-1992 20:19:33

BENEFITS OF ELECTRONIC BILLING
One of the greatest benefits of electronic billing is that less information is required for processing. Less information means less room for error. The data element that are not required on electronic claims include:

- recipient's date of birth
- recipient's address
- provider's name and address
- recipient's sex
- signature of provider

Other benefits of billing electronically include:

- free software
- improved cash flow
- lower detail denial rate
- flexible submission methods
- claim entry controlled by provider
- online edits

To request more information on electronic claims submission contact the Electronic Media Claims (EMC) Department at the address located in Section 4 of the handbook, or fill out the Paperless Claim Request form located at the back of this handbook.

APPENDIX 20
INFORMATION REGARDING TRANSPORTATION TO MEDICAL APPOINTMENTS

Although transportation is not a covered service for home care providers, home care providers often assist clients in making arrangements for transportation. This information is furnished to assist providers when making such arrangements for Medical Assistance recipients.

Transportation to medical appointments (services paid for by the WMAP), including therapy services, may be reimbursable under the WMAP, but transportation for any other purpose (e.g. grocery shopping) is not.

- Recipients are encouraged to drive themselves if at all possible, or to find a friend or relative to drive them. This is a service many volunteer organizations provide.

- If the recipient cannot drive and cannot locate a volunteer driver, and if the recipient can travel by taxi, bus, or the aging program's transportation program, then the recipient is to contact the county.

  When the recipient has transportation needs which may be met by common carrier (i.e. bus, taxi), the county is responsible for meeting those needs.

- In order for SMV transportation to be reimbursable by the WMAP, the following criteria must be met:

  1. The recipient cannot be transported via common carrier (e.g. car, bus, taxi) due to his or her medical condition.

  2. The transportation provider must be currently certified with the WMAP as a SMV provider.

  3. The recipient must be currently eligible for WMAP services.

  4. The recipient's physician has written a prescription which states that his or her medical condition prevents use of a common carrier. If the condition is permanent, only one prescription is required per lifetime. If it is temporary, it must be renewed at 90 day intervals.

SMV providers meet minimal qualifications. The vehicle must be in good running order and must have a fire extinguisher. The driver must be trained to assist passengers having a seizure and must hold a valid driver's license. Home care providers should discuss current regulations with SMV providers before making referrals to assure that the recipient receives appropriate services.

Home health providers who assist clients in making transportation arrangements are encouraged to find the least expensive, but appropriate, means of transportation.

APPENDIX 21
PAPERLESS CLAIMS REQUEST FORM

Please complete this form if you want additional information on electronic billing.

Name: ____________________
Address: ____________________
____
____

Medicaid Number: __________ Phone #: __________
Contact Person: ____________________
Type of Service(s) Provided: ____________________
Estimated Monthly Medicaid Claims Filed: ____________________

* *

1. Do you currently submit your Medicaid claims on paper? __YES __NO

2. Are your Medicaid claims computer generated on paper __YES __NO

3. Do you use a billing service? __YES __NO
   If the answer is YES to #2 or #3, please complete the following:
   Name: __________ Contact: __________
   Address: __________ Phone #: __________
   ____

4. Do you have an in-house computer system? __YES __NO
   If YES, type of computer system:
   a. Large main frame — Manufacturer: __________
      (e.g., IBM 360, Burroughs 3800) — Model #: __________
   b. Mini-Computer — Manufacturer: __________
      (e.g., IBM System 34, or 36 TI 990) — Model #: __________
   c. Micro-Computer — Manufacturer: __________
      (e.g., IBM PC, COMPAQ, TRS 1000) — Model #: __________

5. Please send the paperless claims manual for:

   __ magnetic tape submission

   __ telephone transmission (EDS free software) ___ 3-1/2" ___ 5-1/4"
   (NOTE: EDS does not supply the 3-1/2" diskette. If you need this size, please send a blank formatted diskette with your request.)

   __ telephone transmission (3780 protocol transmission)

Return To: EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009

APPENDIX 22
SUBMITTING CLAIMS FOR MEDICARE DUAL-ENTITLEES

A. When a claim does not cross over automatically or an electronic crossover claim is denied, the provider must submit a paper crossover claim. The complete eight-digit Medical Assistance provider number is required for processing and:

1. Make a copy of the Medicare claim. Be sure that the recipient's Medical Assistance number, the procedure coding of the Wisconsin Medical Assistance Program (WMAP), the single-digit WMAP place of service code and the WMAP provider name and number are on the claim. The claim must also indicate that assignment was accepted. ***NOTE:*** The dollar amount of the claim must match the dollar amount on the EOMB.

2. Make a copy of the Medicare EOMB or RA.

3. Staple the claim form and the EOMB and submit both to EDS.

B. When a crossover claim is not automatic because the recipient was not eligible for Medical Assistance at the time of service and Medical Assistance eligibility was determined retroactively:

1. Follow the instructions in A above.

2. Be sure to note "retroactive eligibility" on the face of the claim form if the dates of service on the claim require that the claim be sent to Late Billing Appeals.

C. When a crossover claim denies for other insurance (rejection code 278 on EDS Remittance and Status Report):

1. Bill the other health insurance.

2. When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA or OTH, and the service requires other health insurance billing according to Appendix 18a of Part A of the WMAP Handbook, one of the following MUST be indicated in the appropriate element on the provider's claim form. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	**Description**
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim. Do not use this code unless the claim in question was actually billed to and paid in part by other health insurance.
OI-D	DENIED by other health insurance following submission of a correct and complete claim or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the private insurer.
OI-Y	YES, card indicates other coverage but it was not billed because for reasons including, but not limited to: - Recipient denies coverage or will not cooperate; - The provider knows the service in question is noncovered by the carrier.

- Insurance failed to respond to initial and follow-up claim; or

- Benefits not assignable or cannot get an assignment.

3. When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	**Description**
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation amount.

When you have not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, or the service does not require third party billing according to Appendix 18a of the Part A, All Provider Handbook, in the "Remarks" section of the UB-92 claim form (or element 26 of the Drug Claim Form) may be left blank.

4. Make a copy of the Medicare claim and EOMB or RA. Staple together and submit both to EDS or you may submit the crossover services electronically.

5. DO NOT attach a copy of the other insurance payment or rejection notice.

NOTE: Medical Assistance does not make a payment unless the amount of the other insurance and Medicare payment is less than the Medicare allowed amount.

D. When Medicare denies a charge for reasons other than medical necessity or billing error (e.g., patient has no coverage, frequency not covered, or lack of skilled intervention make it not a covered benefit under Medicare):

1. Complete a Medical Assistance electronic or paper claim for the denied services only.

2. One of the following Medicare disclaimer codes MUST be indicated in the appropriate element on the provider's paper claim form or in the appropriate field in the electronic format. The description is not required.

Code	**Description**
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.
M-6	Recipient not Medicare eligible.

M-7 Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.

M-8 Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medical Assistance identification card indicates no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefits (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of claims for dual entitlees.

3. Submit to EDS. DO NOT attach a copy of the Medicare EOMB or RA and DO NOT show any Medicare payment on the Medical Assistance claim form. (Documentation must be retained by the provider for possible future review by the WMAP.)

4. DO NOT use an adjustment request form to file for Medicare noncovered charges on a Medicare crossover claim.

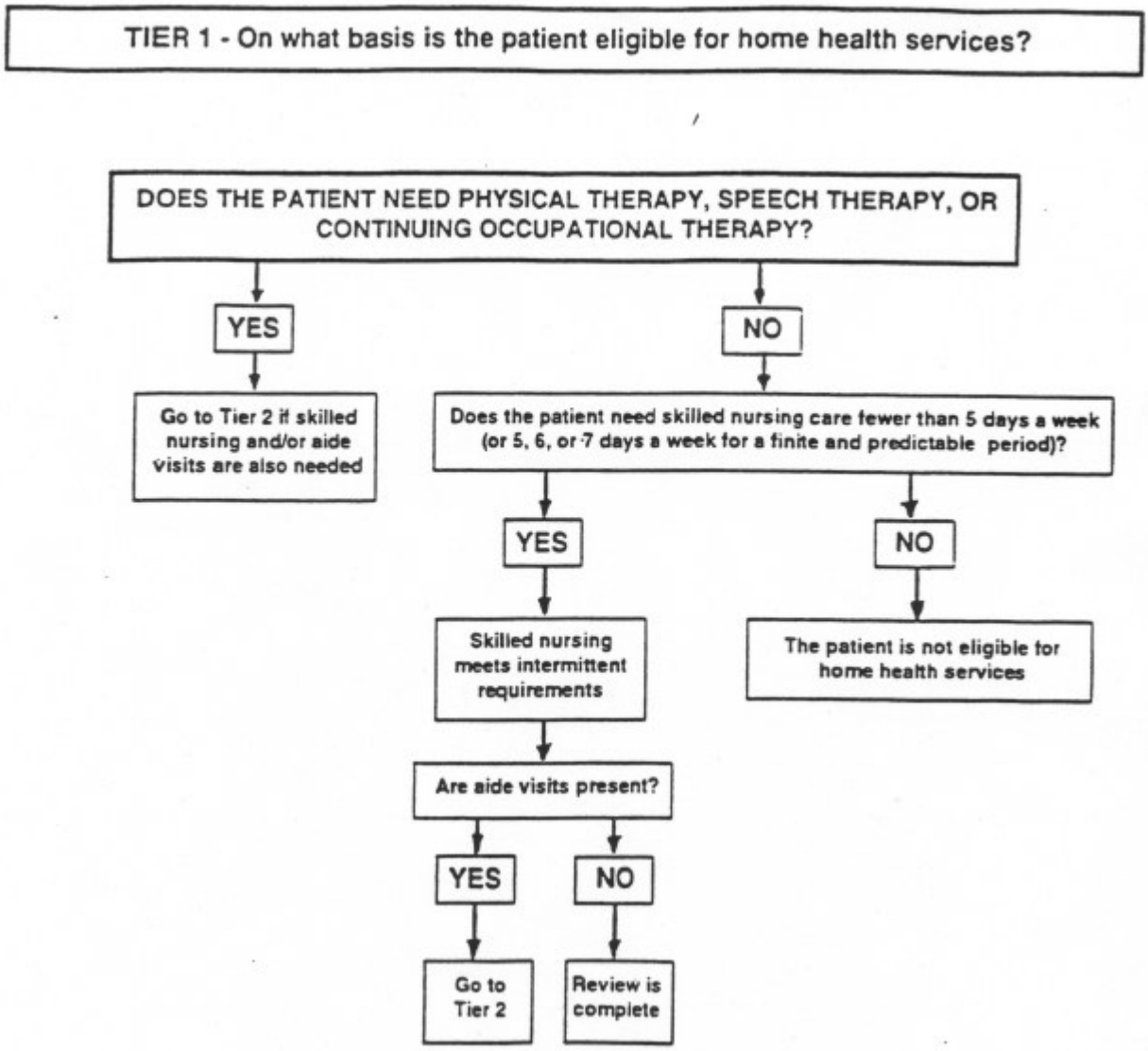
E. When providers need to adjust a Medical Assistance payment on a crossover claim (e.g., the coinsurance was paid incorrectly, or payment on the claim was reconsidered by Medicare) because of reasons such as when a recipient receives retroactive Medicare eligibility:

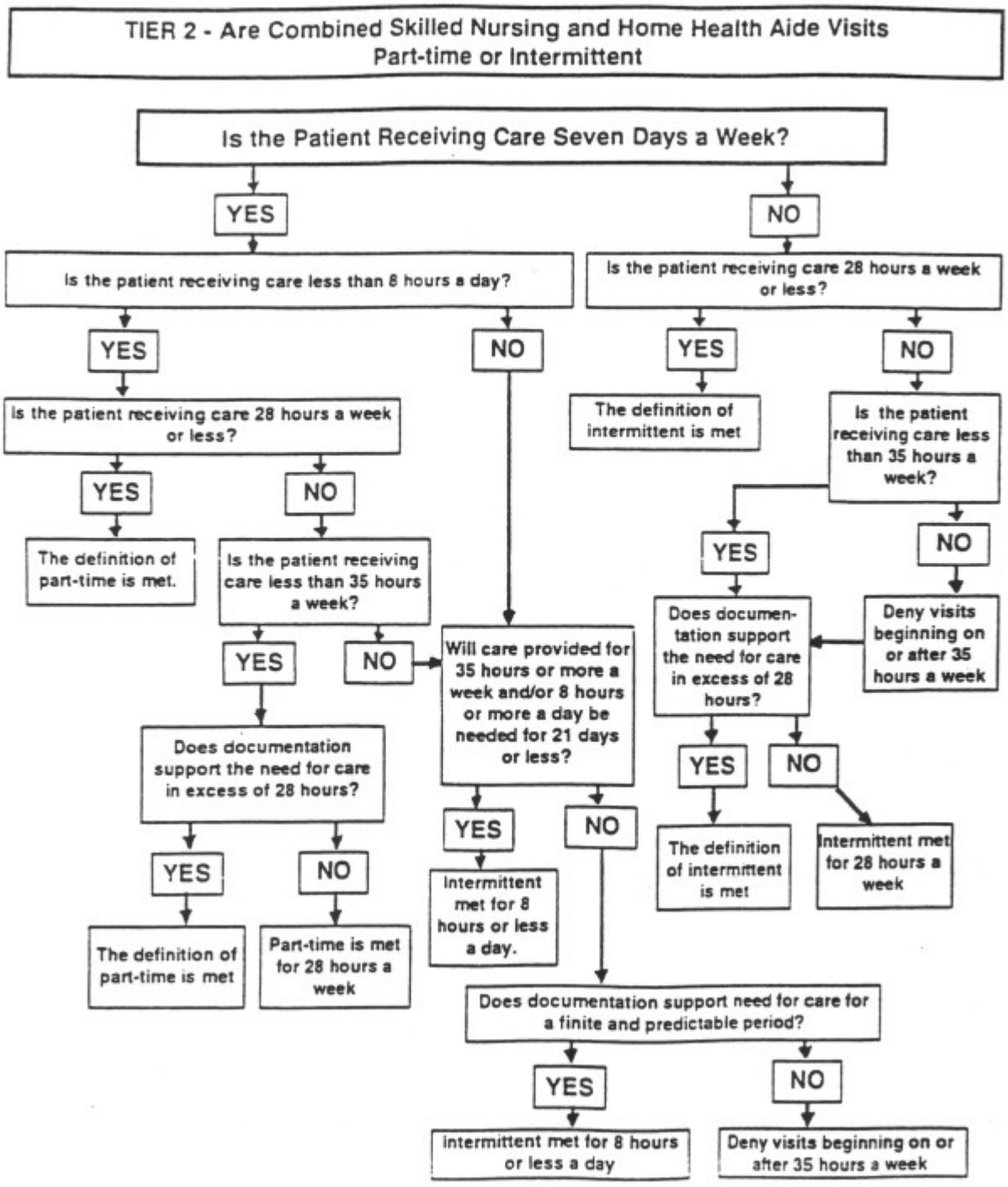
1. Complete an adjustment request form clearly stating the reason for the adjustment. (Do not complete the Medicare information box in the lower right-hand corner.)

2. Make a copy of the Medicare EOMB or RA or Medicare letter. (If this is a reconsideration, copy both of the Medicare EOMBs.)

3. Staple together and submit to EDS.

APPENDIX 23
MEDICARE DESK AID FOR USE IN DETERMINING IF SKILLED NURSING AND/OR AIDE SERVICES FOR A HOMEBOUND CLIENT ARE PART-TIME OR INTERMITTENT




TIER 2 - Are Combined Skilled Nursing and Home Health Aide Visits Part-time or Intermittent
Is the Patient Receiving Care Seven Days a Week?
YES
NO
Is the patient receiving care less than 8 hours a day?
Is the patient receiving care 28 hours a week or less?
YES
NO
YES
NO
Is the patient receiving care 28 hours a week or less?
The definition of intermittent is met
Is the patient receiving care less than 35 hours a week?
YES
NO
The definition of part-time is met.
Is the patient receiving care less than 35 hours a week?
YES
NO
Does documentation support the need for care in excess of 28 hours?
Deny visits beginning on or after 35 hours a week
Will care provided for 35 hours or more a week and/or 8 hours or more a day be needed for 21 days or less?
YES
NO
YES
NO
Does documentation support the need for care in excess of 28 hours?
YES
NO
YES
NO
The definition of intermittent is met
Intermittent met for 28 hours a week
Intermittent met for 8 hours or less a day.
The definition of part-time is met
Part-time is met for 28 hours a week
Does documentation support need for care for a finite and predictable period?
YES
NO
Intermittent met for 8 hours or less a day
Deny visits beginning on or after 35 hours a week

APPENDIX 24
CLAIM SUBMISSION LIMIT POLICY EXAMPLES

The following examples illustrate how providers should submit claims under the claim submission limit policy. Refer to Section IV-G of this handbook for information on the claim submission limit policy.

Example 1: Paid Claim for Multiple Services, Same Calendar Week

A provider dispenses prescriptions for two disposable medical supplies on Sunday, January 2, 1994, and three disposable medical supplies on Tuesday, January 4, 1994, for the same recipient. This sequence of services meets the same recipient, same provider, same calendar week criteria. The provider must submit one paper or electronic claim with five details completed.

Example 2: Paid Claim for Multiple Services, Different Calendar Weeks

A provider dispenses prescriptions for five disposable medical supplies on Sunday, January 2, 1994, and three disposable medical supplies on Wednesday, January 12, 1994, for the same recipient. This sequence of services meets the same recipient, same provider, same calendar week criteria for the five disposable medical supplies, and the same recipient, same provider, same calendar week criteria for the three disposable medical supplies, but the services were provided in two different calendar weeks. Therefore, the provider may combine all services even though they were provided in different calendar weeks and submit one electronic claim, or the provider may submit one paper or electronic claim for the disposable medical supplies, and a second paper or electronic claim for the disposable medical supplies, since the services were provided in different calendar weeks.

Example 3: Paid Claim for Multiple Services, Different Calendar Weeks

A provider dispenses prescriptions for three disposable medical supplies on Sunday, January 2, 1994, and three disposable medical supplies on Wednesday, January 12, 1994, for the same recipient, and bills for all six products on one paper claim. Subsequently, the provider determines that he needs to bill for one more product for week one. The provider may submit an additional paper claim for the seventh product since all six details were used on the first claim, even though the claim was for products dispensed in different calendar weeks.

Example 4: Paid Claim for Prior Authorized and Non-Prior Authorized Services, Same Calendar Week

A provider dispenses a prior authorized disposable medical supply on Sunday, January 2, 1994, and a non-prior authorized disposable medical supply on Tuesday, January 4, 1994. Since only one service was prior authorized, the services must be combined and submitted as one claim to the WMAP.

Example 5: Paid Claims for Multiple Prior Authorized Services, Same Calendar Week

A provider dispenses a prior authorized disposable medical supply on Sunday, January 2, 1994, and a different prior authorized disposable medical supply on Wednesday, January 5, 1994, for the same recipient. Since two services were prior authorized, the provider must submit two claims with two different prior authorization numbers. Even though both claims contain only one service, the claims are paid because the services require two different prior authorization numbers and are, therefore, exempt from the claims submission limit policy.

Example 6: Paid Claims for Services Provided in the Same Provider Defined Calendar Week, With One Service Billed to Other Insurance

A provider has a Thursday through Wednesday billing cycle. The provider dispenses three disposable medical supplies on Friday, January 7, 1994, and two legend drugs on Tuesday, January 11, 1994. One of the disposable medical supplies dispensed on Tuesday is covered by other insurance. This sequence of services meets the same calendar week (provider defined) criteria for four of the services and the second claim submission criteria for the firth service. The provider may submit one claim for the three services provided on Friday and the service provided on Tuesday which is not covered by other insurance. The provider may submit a second claim for the second service provided on Tuesday at a later date after the other insurance processes the claim.

In this instance, the provider may not submit a separate claim for the services provided on Friday, a separate claim for the service not covered by other insurance provided on Tuesday, and a third claim at a later date for the Tuesday service processed by other insurance. The provider must:

- Combine all services, except the one covered by other insurance, onto one claim and later submit a claim for the service processed by other insurance; or

- Submit a claim for the services provided on Friday, a second claim for the service not covered by other insurance provided on Tuesday, and adjust the second claim for additional payment of the service provided on Tuesday after it is processed by other insurance.

Under no circumstances is a third claim submission per calendar week, per provider, per recipient allowed unless the service billed is exempt from the drug claim billing limit policy.

Example 7: Denied Claim for Multiple Services, Same Calendar Week

A provider dispenses two disposable medical supplies on Sunday, January 2, 1994, and three disposable medical supplies on Tuesday, January 4, 1994, for the same recipient. This sequence of services meets the same recipient, same provider, same calendar week criteria. The provider submits one paper or electronic claim with five details completed. However, the provider transposes digits in the NDC for one of the disposable medical supplies and this detail denies. The provider finds the error, corrects it, and refiles the claim with the paid details crossed out. This claim will be denied. In order for the provider to be reimbursed for the denied detail, the provider must submit an adjustment to the original claim with the corrected NDC.

Example 8: Denied Claims for Multiple Services, Same Calendar Week

A provider dispenses two disposable medical supplies on Sunday, January 2, 1994, and four disposable medical supplies on Tuesday, January 4, 1994, for the same recipient. This sequence of services meets the same recipient, same provider, same calendar week criteria. If the provider submits six separate claims, one claim will be processed and paid. However, the other five claims will be denied since all six services should have been submitted on the same claim form. In order for the provider to be reimbursed for the denied claims, the provider must submit an Adjustment Request Form and adjust the first paid claim to add the five denied services.

Example 9: Denied Claims for Multiple Services, Same Calendar Week

A provider dispenses five disposable medical supplies on Sunday, January 2, 1994, five disposable medical supplies on Tuesday, January 4, 1994, and three disposable medical supplies on Wednesday, January 5, 1994, to the same recipient. This sequence of services meets the same calendar week, same provider, same recipient criteria. The provider should submit one electronic claim or three paper claims for the 13 services. If the provider submits one electronic claim for the five legend drugs, a second electronic claim for the disposable medical supplies, and a third electronic claim for the disposable medical supplies, the second and third claims will be denied. In order for the provider to be reimbursed for the denied claims, the provider must submit an Adjustment Request Form and adjust the first paid claim.